



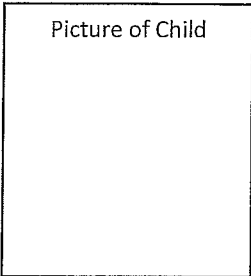
# Asthma Action Plan

Picture of Child

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



| Severity Classification   | Triggers  | Exercise  |
|---|---|---|
| <input type="checkbox"/> Intermittent<br><input type="checkbox"/> Mild Persistent<br><input type="checkbox"/> Moderate Persistent<br><input type="checkbox"/> Severe Persistent | <input type="checkbox"/> Colds <input type="checkbox"/> Smoke <input type="checkbox"/> Weather<br><input type="checkbox"/> Exercise <input type="checkbox"/> Dust <input type="checkbox"/> Air Pollutions<br><input type="checkbox"/> Animals <input type="checkbox"/> Food<br><input type="checkbox"/> Other _____ | 1. Premedication (how much and when)<br>_____<br>2. Exercise modifications<br>_____ |

**Green Zone: Doing Well**      **Peak Flow Meter/Personal Best =**

| <b>Symptoms</b> <ul style="list-style-type: none"> <li>Breathing is good</li> <li>No cough or wheeze</li> <li>Can work and play</li> <li>Sleeps well at night</li> </ul> <b>Peak Flow Meter</b><br>More than 80% of personal best or _____ | <b>Control Medications:</b><br><table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> | Medicine        | How Much to Take | When to Take It | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
|--|--|-----------------|------------------|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Medicine   | How Much to Take   | When to Take It |                  |                 |       |       |       |       |       |       |       |       |       |
| _____  | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |
| _____  | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |
| _____  | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |

**Yellow Zone: Getting Worse**      **Parent/Guardian to contact physician if using quick reliever more than 2 times per week**

| <b>Symptoms</b> <ul style="list-style-type: none"> <li>Some problems breathing</li> <li>Cough, wheeze, or chest tight</li> <li>Problems working or playing</li> <li>Wake at night</li> </ul> <b>Peak Flow Meter</b><br>Between 50% and 80% of personal best or _____ to _____ | <b>Control Medications:</b><br><table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> | Medicine        | How Much to Take | When to Take It | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
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| Medicine  | How Much to Take   | When to Take It |                  |                 |       |       |       |       |       |       |       |       |       |
| _____   | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |
| _____   | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |
| _____   | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |

|  |   |
|--|---|
| <b>If your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN</b><br><input type="checkbox"/> Take quick-relief medication every 4 hours for 1 to 2 days<br><input type="checkbox"/> Change your long-term control medicine by _____<br><input type="checkbox"/> Contact your physician for follow-up care. | <b>If your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN</b><br><input type="checkbox"/> Take quick-relief treatment again.<br><input type="checkbox"/> Change your long-term control medicine by _____<br><input type="checkbox"/> Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine. |
|--|---|

| <b>Symptoms</b> <ul style="list-style-type: none"> <li>Lots of problems breathing</li> <li>Cannot work or play</li> <li>Getting worse instead of better</li> <li>Medicine is not helping</li> </ul> <b>Peak Flow Meter</b><br>Less than 50% of personal best or _____ to _____ | <b>Continue control medications and add</b><br><table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> | Medicine        | How Much to Take | When to Take It | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
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| Medicine   | How Much to Take   | When to Take It |                  |                 |       |       |       |       |       |       |       |       |       |
| _____  | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |
| _____  | _____  | _____           |                  |                 |       |       |       |       |       |       |       |       |       |
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